Without Social Psychiatry, there is no Psychiatry. Discuss.

Summary

Social Psychiatry has played a key role in the development of Psychiatry as a whole. This essay, acknowledging the somewhat vague meaning of the term 'Social Psychiatry', briefly summarises its usage in the literature in order to arrive at a definition. Three connotations of the term are identified:

1. An area of theoretical and empirical science (primarily psychiatric epidemiology and sociology)

2. A political movement (essentially psychiatric public health)

3. A way to practice healthcare (synonymous with community psychiatry, or extramural psychiatry as it sometimes appears)

The degree to which each of these areas is fundamental to the psychiatric field is then respectively assessed.

1. Psychiatric epidemiology is indispensable to the profession by virtue of the subjectivity of the psychiatric diagnosis. Sociological research is essential to identifying disorders which present differently across cultures.

2. Psychiatric public health measures have historically been infrequent despite their effectiveness. However, on the background of an international human resources crisis across mental health services, psychiatric public health legislation represents a highly efficient countermeasure to this crisis.

3. Whilst mental health services in high-income countries are oriented primarily around community provision, services in low- and middle-income countries unnecessarily institutionalise many of their patients due to underprovision in the community. With this situation in mind, advocacy for community psychiatry is still very much necessary.

In conclusion, social psychiatry is essential to psychiatry as a whole, and without it the profession would be significantly less advanced – particularly considering the role social psychiatry played in the profession's historical development.

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Without Social Psychiatry, there is no Psychiatry. Discuss.

Social Psychiatry, much like Psychiatry itself, has a long and storied past. The usage of the term has varied frequently over the last century. In order to be debated, it must first be understood. This is best done by examining its usage in the literature.

In 1903, Georg Ilberg, from the Groß-Schweidnitz asylum in Saxony, published 'Soziale Psychiatrie'[1]. This paper was the first mention of the term 'Social Psychiatry'[2], which Ilberg defined as the study of the socioeconomic determinants of mental health. Ilberg held that the first tasks of this field would be to reduce alcohol intake, to eradicate syphilis, and to prevent marriage between the healthy and mentally ill, with the premise that most mental illnesses had a hereditary component. The term resurfaced in 1911, in a paper written by Max Fischer, psychiatric director of the Wiesloch asylum, advocating extramural psychiatry. Fischer argued for intense investigation into the social issues affecting Germany at the time, brought to a head by WWI. He addressed the problem of racial hygiene, and called for marriage to be forbidden to 'degenerates, idiots, and severe epileptics', stressing that 'there could be no psychiatry without social psychiatry[3].'

It is not surprising that social psychiatry would emerge from the Germanosphere, considering this is where psychiatry itself has its roots, in the form of psychoanalysis[4]. Neither is it surprising that eugenics and racial hygiene would enter the psychiatric discussion considering the political ideas endemic in the region at the time. As the idea spread, it was reduced to the concept of

prevention based on sterilization[5]. This idea was further propagated by characters such as Karl Binding, Alfred Hoche, and Berthold Kihn, firmly taking root in the National Socialist party[6]. This culminated in the greatest criminal act in psychiatric history: the murder of 275,000 psychiatric patients, and the sterilisation of a further 400,000[7].

A decade would pass following WWII before the term 'social psychiatry' would lose enough stigma to reappear in the literature. When it did – in the 1950s – it was used in a very generic sense, encompassing topics as broad as the philosophical reflection on the relationship of the individual with society, the increasing consensus to more firmly establish community psychiatry and deinstitutionalise asylum patients, and the analysis of the social psychiatry movement in America[8]. Interestingly, as Dunham noted in 1948, the American movement arose independently of the German tradition, emerging as "a creation of the sociologists doing research in the field of personality disorder[9]."

American psychiatry in the 1960s saw significant competition between three major disciplines: biopsychiatry, psychoanalysis, and social psychiatry[10]. In America, the premise of the latter was that mental illness was caused primarily by socio-economic factors (substantiated by a significant amount of research of the period[11] [12] [13] [14]) and, therefore, could be prevented by alleviating poverty, crime, and substance abuse[15]. Many psychiatrists saw political involvement as a responsibility of their profession, in order to eliminate such pathogenic conditions[16] [17]. It was in this period, and with reference to these ideas, that Dorner wrote: "psychiatry is social psychiatry or it is no psychiatry[18]." This form of social psychiatry was the dominant school of psychiatric thought at the time,

and was strongly endorsed by the American Psychiatric Association[19]. These ideas were reflected in President Kennedy's 1963 Message to the United States Congress on Mental Illness and Mental Retardation[20]. Kennedy emphasised eliminating the environmental causes of mental illness (particularly poverty), and called for a shift from isolated state hospitals (a system he called 'social quarantine') towards the smaller, localised community mental health centres that social psychiatry promoted[21]. Following Kennedy's assassination, Congress passed the Community Mental Health Centers Construction Act in late 1963, realising some of the President's aspirations[22].

However, enthusiasm for this newfound approach began to wane. While social psychiatry's ideas were plausible to many, its preventative socioeconomic remedies proved impractical to implement, difficult to substantiate through scientific trials, and unable to provide an immediate solution[23]. In addition, America's involvement in Vietnam drew resources away from mental health programmes[24], and given that biopsychiatry was able to demonstrate relative – and immediate – success with pharmacological management, it became a much more promising avenue of investigation. Social psychiatry faded from the pages of the psychiatric journals by the late 70s, and has not since re-emerged as a force within the American profession[25].

Nevertheless, social psychiatry was fundamental to deinstitutionalisation in the west. Psychiatry changed radically during the Second World War. Combat disorders led to increased recruitment and a diversity of new approaches. Maxwell Jones, a luminary social psychiatrist, noted that rank and status interfered excessively with the treatment of servicemen. He encouraged

informality and cooperation between patients, allowing them to deal with their problems in a democratic, optimistic, and enquiring group environment[26]. Jones' follow-up studies six months after treatment found two-thirds of his patients had made a fair adjustment or better, and over one-half had worked the full time since leaving. These were the first 'therapeutic communities'. Jones' ideas spread rapidly across Britain and further afield, becoming widely implemented in psychiatric hospitals[27]. The evidence in favour of Therapeutic Communities was positive, indicating reduced chronicity and institutionalisation[28]. It was at this point that the detrimental effects of institutionalisation were beginning to be understood: a study comparing three hospitals in the 1960s found marked variance in levels of self-neglect and apathy, depending on the levels of variety provided by hospital routines[29]. However, institutionalisation would only be understood for the crisis it was following intense criticism from the anti-psychiatry movement.

Anti-psychiatry can be considered a branch of social psychiatry[30]; both argue for the sociological pathogenesis of mental illness. However, the anti-psychiatrists (primarily Szasz and Laing) debated the very basis of psychiatric diagnosis. Both authors, whilst widely discussed, failed to have a significant impact on clinical practice[31] [32]. However, Goffman – and to a lesser extent, Foucault – were instrumental to popularising deinstitutionalisation[33]. Goffman's *Asylums* (1961) remains the most quoted text in sociology[34], and Foucault the most cited author[35]. Goffman's thesis, of the asylum as a closed society which manipulated its members into pathological behaviours, was also anticipated by Russel Barton in the UK, who coined the term 'institutional neurosis' to describe a similar

phenomenon[36]. This criticism of the profession, alongside biopsychiatry enabling the pharmacological management of psychiatric conditions outside the hospital, led to a 90% population-adjusted reduction in psychiatric inpatient numbers in the US and UK between 1955 and 2018[37]. Despite this, the anti-psychiatry movement has been identified as a significant cause of the modern profession's wariness of sociology and social psychiatry[38].

Social psychiatry in Britain, in comparison to Europe, enjoys no strong history[39], but work by British psychiatrists such as Michael Shepherd in the 1960s revealed the importance of strengthening primary care provision to bolstering mental health services overall[40]. Shepherd, working in the Maudsley hospital in the 70s, trained nurse therapists in psychological therapies, beginning a transfer of skills from psychiatrists to other mental health professionals that truly came into its own under the Increasing Access to Psychological Therapies (IAPT) programme, introduced by the Labour government in 2006[41]. Following deinstitutionalisation, the ethos of social psychiatry was more fully realised by the community psychiatry provisions deployed to replace the asylums in the UK[42], Italy[43], the Netherlands[44], and elsewhere in Europe[45].

From this brief summary, it is evident that the term 'Social Psychiatry' has represented a myriad of fields and methods. Priebe and Finzen, addressing this ambiguity at the turn of the century, outline three primary connotations of the term[46]:

1. an area of theoretical and empirical science (encompassing both psychiatric epidemiology and the sociological analysis of mental illness)

2. a political movement (encompassing psychiatric public health)

3. a way to practise mental health care (encompassing community psychiatry)

The degree to which each of these three areas is fundamental to modern psychiatry will now be addressed. It is possible at this point to address the essay title in another sense of its meaning: without social psychiatry, there is no psychiatry *as we know it*. Psychiatry developed – and continues to, being as yet an immature field – via a Hegelian dialectic, following a thesis-antithesis-synthesis pattern. At each cycle, the concept of the psyche is refined, and treatments for its aberrations sharpened. It can certainly be argued that social psychiatry has played such a large part in the development of psychiatry that without its ideas (particularly those of deinstitutionalisation and community psychiatry), psychiatry could barely be considered a medical profession.

An Area of Theoretical and Empirical Science

That psychiatric epidemiology is an essential component of psychiatry is not under debate[47]. Indeed, as psychiatric diagnoses are mostly made on the basis of subjective – rather than objective – measures[48], epidemiology is necessary to define diagnoses[49], and is therefore perhaps more important to psychiatry than any other branch of medicine.

What may, however, be debated is the assertion that the sociological analysis of mental illness is essential to psychiatry. There is much evidence in favour of this assertion. Socioeconomic status reliably correlates with improved mental wellbeing[50]. In animal models, social status modulates the activity of

serotonergic pathways[51], the underactivity of which has been hypothesised to be a causative factor for major depressive disorder[52]. Mental illness is understood as being a result of a complex interplay between genetic and social factors[53].

However, psychiatry, as a branch of medicine, concerns itself with identification and treatment of disease. Whilst it draws on topics such as sociology, why should psychiatric research be oriented in this direction considering the fact that findings are likely to be of little clinical value?

Firstly, unlike the rest of medicine, psychiatry does not understand the thing it is trying to treat – the brain – to a necessary degree of detail. This shifts the balance of investigation in favour of a multidisciplinary approach, which in the absence of a unifying theory, is statistically more likely to yield results. This can be more simply articulated as 'the more things you try, the more likely you are to find things that work'. Indeed, many of science's great leaps forward have been serendipitous: Penicillin[54], the structure of DNA[55], and X-rays[56], to name but a few.

Secondly, the psychiatric diagnosis has a unique relationship with the society and culture in which it exists. It is well documented that human expression of psychological trauma – whether conscious or not – is socially modulated. This phenomenon exists as a spectrum, ranging from conversion disorders to mass hysteria. Mass hysteria can be traced as far back as the Dancing Plagues of the Middle Ages. The most popular explanation for these events is the ergot poisoning theory. However, John Waller in *The Lancet*[57] debates this:

"...it is unlikely that those poisoned by ergot could have danced for days at a time. Nor would so many people have reacted to its psychotropic chemicals in the same way. The ergotism theory also fails to explain why virtually every outbreak occurred somewhere along the Rhine and Moselle Rivers, areas linked by water but with quite different climates and crops."

Waller instead proposes that the dancing was an expression of "stress-induced psychosis" on a mass level, owing to the levels of starvation and disease endemic in the region, which were exceptionally harsh even by the standards of the time[58]. He argues that the reason for this unique expression of psychological distress is these societies' profound fear of 'wrathful spirits able to inflict a dancing curse', attested to by sources including altar paintings, chronicles, and law books. This argument is further supported by anthropological field studies of 'possession rituals' in the Arctic, the Andes, the Kalahari, and the Caribbean, which show that people are more likely to enter trance states if they expect them to happen[59].

This phenomenon (of societally modulated expression of psychological trauma) was again observed during the world wars. WWI servicemen, unable to acknowledge their terror, developed 'shell shock' (characterised by a course tremor and excitability). They were genuinely unaware that this was caused by the fear of battle. During WWII, it was widely acknowledged that soldiers could be terrified by battle, and soldiers who couldn't cope developed 'combat stress' rather than shell shock. They did not have to deny the fear and convert it into more socially acceptable symptoms such as tremor and paralysis[60].

This phenomenon is also observed in the modern day, in the prevalence of wrist-cutting as a means of self-harm[61], and in the incidence of conditions such as Anorexia and Bulimia, which originated in the west and appear to track the spread of the western feminine beauty ideal[62] [63].

Thirdly, the rapid changes of modernity have profoundly impacted human social behaviour. Internet use is associated with decreased family communication and reduced social circle size[64]. Internet and gaming addictions have materialised as disorders[65]. A number of studies link increased internet use with depressive symptoms[66], but internet use is not homogenous, and there is also the potential to exploit its benefits in finding new communities. Nonetheless, much remains unknown[67].

For these reasons, it is imperative that the modern psychiatrist be studied in sociology. The profession's historical pathologizing of homosexuality is a stark indication of the subjectivity of the psychiatric diagnosis[68]. Constant self-criticism is key to objectivity, and by losing the outside perspective that sociology provides, psychiatry becomes more liable to fall prey to subjectivity, and to repeat the mistakes of the past.

A Political Movement

A recent systematic review observed a dramatic increase in income inequality in most countries over the last three decades, and found significant positive relationships between income inequality and incidence rates of schizophrenia and depression. The authors recommend policy makers should actively promote actions to reduce income inequality, such as progressive taxation and universal

basic income[69]. These findings, whilst important, are far from novel. Reducing economic inequality is widely accepted as a fundamental means of reducing the burden of psychiatric disease[70] [71].

Not only is the data favourable, but psychiatric public health measures have also proven effective historically. Reducing pack sizes for dangerous medications has significantly reduced suicides in the UK[72]. A meta-analysis found a reduction in suicide rates in Australia following enactment of legislation to limit access to firearms[73]. Programmes to restrict access to deadly pesticides in India have ameliorated the suicide crisis in poor, indebted farmers[74]. The Nordic countries (Denmark, Sweden, Norway, Finland, and Iceland) have some of the lowest income inequality measures in the world[75] , and (as oft-reported) consistently rank within the top ten countries for happiness according to the UN and OECD[76], potentially suggesting a causal relationship.

Despite this, there is a lack of psychiatric public health activity in western industrialised nations[77] [78]. This may be because the interventions it proposes relate to economic and fiscal policy, and this arena is ideologically fraught. Furthermore, meaningful change in this arena would require significant political involvement from the psychiatric community, impairing their ability to fulfil the healthcare requirements of their profession.

It would appear that this cannot be justified in the current climate. The King's Fund found UK mental health staff shortages acute enough to close wards[79]. Many sources point to a human resources crisis in mental health services worldwide, particularly in low- and middle-income countries[80] [81].

However, a systematic review of 52 studies relating to return on investment (ROI) of public health interventions found a median ROI of 14.3, suggesting that local and national public health interventions are, in the long run, 'highly cost-saving'[82]. In light of the recent increase in the global burden of mental illness[83], it is imperative that investments in mental health services are made in an optimal manner. For this reason, and bearing in mind the proven potential of psychiatric public health, it may be concluded that this branch of psychiatry is of pivotal importance to the profession.

A Way to Practice Healthcare

The contributions of social psychiatry to the wider profession (in the form of the movements toward deinstitutionalisation and community care) have already proven its importance to psychiatry as a whole. The majority of mental health provision is in the community, and the psychiatric hospitals operate at the peripheries of the mental health services in the western world[84]. Given this, it could be said that social psychiatry has fulfilled its purpose. Thus, we return to the initial question of whether social psychiatry continues to be important.

'Reinstitutionalisation' has been observed in the UK and across Europe in recent years. This is not necessarily a negative trend – only time will tell, but the study which made this observation[85] notes that the trend may reflect the zeitgeist towards risk containment in 21st century western society, rather than being driven by healthcare needs.

Another paper notes that, despite the stated policy objectives of deinstitutionalization and integration of inpatient mental health care in low- and

middle-income countries, 74.4% of psychiatric beds are to be found in psychiatric hospitals[86]. The paper continues:

> "Drug treatments and custodial treatments dominate in large psychiatric hospitals, many of which are relics of the colonial era; in such hospitals, care is often compromised by poor standards, lack of community care programmes to improve the odds that patients who have been discharged are able to recover fully and remain in good health and, in some instances, denial of basic human rights."

It appears that the hard-fought battle social psychiatry made for deinstitutionalisation is not yet won. For many parts of the world, social psychiatry could not come soon enough.

So, is there psychiatry without social psychiatry? Perhaps. A psychiatry which is ignorant of the sociocultural context of its patients, so cannot recognise their trauma. A psychiatry which is constantly reactive, never able to prevent or pre-empt its disorders. A psychiatry which locks away its patients in asylums and drugs them into a stupor. Whether this continues to constitute psychiatry is left to the reader.

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